South Dakota State Board of Dentistry
P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079
Ph: 605-224-1282 Fax: 1-888-425-3032

E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.org

DENTIST NITROUS OXIDE SEDATION AND ANALGESIA APPLICATION

Pursuant to ARSD § 20:43:09:05 you must submit the following:

1. Application Fee of $50 (check or money orders only, do not send cash);
2. A copy of your current Board approved cardiopulmonary resuscitation (CPR) card. A Board approved CPR course is a course intended for a Healthcare Provider that meets the required knowledge and objectives outlined in the American Heart Association guidelines for BLS or American Heart Association Guidelines for CPR and ECC, and includes a hands-on skills assessment;
3. Proof of successful completion of a nitrous oxide sedation and analgesia course taken through an American Dental Association Commission on Dental Accreditation (CODA) accredited dental, dental hygiene or dental assisting school, and proof that you:
    a. Completed the course within thirteen months prior to application; or
    b. Completed the course more than thirteen months prior to application, have legally administered nitrous oxide inhalation analgesia for a period of time during the three years preceding application, and attest to your current clinical proficiency to administer nitrous oxide sedation and analgesia below.

Name: _____ License #:_____

Employer Office: _____ Phone: _____

Address: _____City, State, Zip: _____

Satellite Office: _____ Phone: _____

Address: _____City, State, Zip: _____

If you have more than one satellite office, please include that information on another page.

If you completed your nitrous oxide sedation and analgesia course more than thirteen months prior to application, please compete the following: *I hereby certify that I have legally administered nitrous oxide sedation and analgesia in another state during the three years preceding application and that I am currently clinically proficient to administer nitrous oxide sedation and analgesia.*

Signature: _____ Date: _____

I declare and affirm that I have read and I am compliant with ARSD § 20:43:09. I declare and affirm under the penalties of perjury that this application has been examined by me and to the best of my knowledge and belief is in all things true and correct.

Signature: _____ Date: _____

Printed Name: _____

Mail completed application and $50.00 application fee to:
South Dakota State Board of Dentistry
PO Box 1079
Pierre, SD 57501

For Office Use Only:
Check # _____
Amount _____
Date _____